STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005035	A. BUILDING: _____ B. WING _____	07/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HANCOCK REGIONAL HOSPITAL	801 N STATE ST GREENFIELD, IN 46140

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS HFAP Surveyor: 34586 Facility Number: 005035 Type of Survey: State Licensure Off Site HFAP Accreditation Survey Date of HFAP On Site Survey - Hospital full survey 7/14-16/ 2014 Date of ISDH off site review -10/20/2014 Reviewer/Surveyor Kerry Sawin RN, PHNS Based on review of the July 14-16/2014 HFAP Accreditation Survey Report, it has been determined that Hancock Regional Hospital meets the requirements for Hospital Licensure in Indiana for 2014.	S 000		